ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

* *

To avoid unnecessary denial or inaccurate claim payment, providers must utilize the following claim form completion instructions. Enter all required data on the face of the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless 'optional' or 'not required' is specified.

Wisconsin medical assistance recipients receive a medical assistance ID card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. This card should always be presented prior to rendering the service. Please use the information exactly as it appears on the ID card to complete the information in the Patient and Insured (subscriber) Information Section.

Program Block/Claim Sort Indicator

Enter the appropriate **CLAIM SORT INDICATOR** for the service billed in the Medicaid check box in the upper left-hand corner of the claim form. Claims submitted without this indicator are denied.

'D' - Corrective Shoes
- Durable Medical Equipment (unless dispensed by a therapist)
- Hearing Aids

'M' - Independent Nurse
- Mental Health - 51.42 Board Operated AODA, Day Treatment, Psychotherapy
- Nurse Midwife
- Rehabilitation Agency
- Community Care Organization

'P' - Chiropractor
- Family Planning

ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

* *

'P' - Free Standing Ambulatory Surgery Center
- Independent Laboratory and Radiology
- Mental Health - Non-51.42 Board Operated AODA, Day eatment, Psychotherapy
- Physician
- Rural Health Agency

'T' - Therapy - Occupational, Physical, Speech, Audiology
- Durable Medical Equipment Dispensed by Occupational, Physical or Speech Therapist

'V' - Vision - Optometrist, Optician, Dispensing Ophthalmologist

ELEMENT 1 - PATIENT NAME
Enter the recipient's last name, first name and middle initial as it appears on his/her current medical assistance identification card.

ELEMENT 2 - PATIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., January 5, 1978 would be 01/05/78) as it appears on his/her medical assistance identification card.

ELEMENT 3 - INSURED'S NAME
If the recipient's name (element #1) and insured's name (element #3) are the same, enter 'SAME' or leave the element blank. When billing for a newborn, enter the mother's last name, first name, middle initial and date of birth in MM/DD/YY format.

ELEMENT 4 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence; if the recipient is a resident of a nursing home, enter the name and address of the nursing home.

ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

* *

ELEMENT 5 - PATIENT'S SEX
Specify if male or female with an 'X'.

ELEMENT 6 - INSURED'S ID NUMBER
Enter the recipient's ten digit medical assistance ID number as found on his/her medical assistance identification card.

ELEMENT 7 - PATIENT'S RELATIONSHIP TO INSURED (not required)

ELEMENT 8 - INSURED'S GROUP NUMBER (not required)

ELEMENT 9 - OTHER INSURANCE
Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP if the service is one of those identified in the Billing Information section of the WMAP Provider Handbook, Part A. When the recipient's medical assistance card indicates other coverage, one of the following codes MUST be indicated. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID by other insurance
OI-D	DENIED by other insurance, benefits exhausted, deductible not reached, non-covered service, etc.
OI-C	Recipient or other party will NOT COOPERATE
OI-S	SENT claim, but insurance company did not respond
OI-R	RECIPIENT denies coverage
OI-E	ERISA plan denies being prime
OI-A	Benefits NOT ASSIGNABLE
OI-H	Denied payment. Private health maintenance organization (HMO) or health maintenance plan (HMP) denied payment due to one of

ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

* *

the following: non-covered/family planning service, or paid amount applied to the recipient's coinsurance/deductible.

If the recipient's medical assistance card indicates no other coverage, the element may be left blank.

ELEMENT 10 - IS CONDITION RELATED TO
If the condition is the result of an employment-related, auto or other accident, enter an 'X' in the appropriate box for items 'A' and 'B'.

ELEMENT 11 - INSURED'S ADDRESS
This element is used by the WMAP for Medicare information. Medicare must be billed prior to the WMAP. When the recipient's medical assistance card indicates Medicare coverage, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Service denied/rejected by Medicare
M-8	Not a Medicare benefit

If the recipient's medical assistance card indicates no Medicare coverage, this element may be left blank.

ELEMENT 11A - (not required)

ELEMENTS 12 - 13
(Not required, provider automatically accepts assignment through medical assistance certification.)

ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

* *

ELEMENT 14 - DATE OF ILLNESS OR INJURY (not required)

ELEMENT 15 - DATE FIRST CONSULTED FOR CONDITION (not required)

ELEMENT 16 - (not required)

ELEMENT 16A - EMERGENCY
Enter an 'X' if emergent.

ELEMENT 17 - (not required)

ELEMENT 18 - (not required)

ELEMENT 19 - REFERRING PHYSICIAN
This is a required element if the billed services were the result of a referral or were ordered by another practitioner. Enter the referring/ prescribing physician's name and eight digit medical assistance number, if available.

ELEMENT 20 - HOSPITALIZATION DATES (not required)

ELEMENT 21 - NAME AND ADDRESS OF FACILITY
If the services billed were performed at a facility other than the recipient's home or the provider's office (i.e., nursing home or hospital), enter the name, address and, if available, the eight digit medical assistance provider number.

ELEMENT 22 - LAB WORK, PLACE OF SERVICE (not required)

ELEMENT 23A - DIAGNOSIS

ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

* *

The International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ('E') codes may not be used as a primary diagnosis.

HEARING AID DEALERS enter Diagnosis Code 389.9

ELEMENT 23B - EPSDT/FAMILY PLANNING INDICATOR/PRIOR AUTHORIZATION NUMBER

EPSDT

If the services were performed as a result of an EPSDT/HealthCheck referral, check 'YES'; otherwise check 'NO'. EPSDT/HealthCheck indicators may not be left blank; a positive or negative response must be indicated.

Family Planning

If the recipient is receiving family planning services only, enter an 'X' in 'YES'. If none of the services are related to family planning, enter an 'X' in 'NO'.

Prior Authorization

The seven digit prior authorization number from the approved prior authorization form/SOIA form must be entered in element 23B. Do not attach a copy of the prior authorization to the claim. Services authorized under multiple prior authorizations must be billed on separate claims.

ELEMENT 24 - SERVICES

Element 24A - Date of Service

In column A, enter the month, day and year in MMDDYY format for each procedure. It is allowable to enter up to four dates of service per line item for each procedure if:

ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

* *

* All dates of service are in the same calendar month.
* All procedures performed are identical.
* All procedures were performed by the same provider.
* The place and type of service is identical for all procedures.
* The same diagnosis is applicable for each procedure.
* The charge for all procedures is identical. (Enter the charge per service following the description in element 24C.)
* The number of services performed on each date of service is identical.

Element 24B - Place of Service

Enter the appropriate place of service code in column B for each service. Refer to Attachment A-5 and A-5a of this bulletin for a list of allowable place of service codes for speech therapy.

Element 24C - Procedure Code and Description

Enter the appropriate procedure code and matching description for each service performed. Enter a written description which is concise, complete and specific for each billed service.

Beneath the description of service, enter the name and eight digit provider number of the performing provider if different than the billing provider indicated in element 31.

Speech and Audiology Providers:

Enter the total number of therapy/services for this line item and the total number of minutes for each therapy (e.g., 30 or 60 minutes for each).

ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

* *

Element 24D - Diagnosis Code Reference

When multiple procedures/diagnoses are submitted, column D must be utilized to relate the procedure performed (element 24C) to a specific diagnosis in element 23A.

The diagnosis code itself may be entered in column D, or enter the line number from element 23A (i.e., 1, 2, 3 or 4) of the appropriate diagnosis as shown on the claim example.

Element 24E - Charges

Enter the total charge for each line item.

Element 24F - Days or Units

Enter the total number of services billed on each line item.

Speech Providers:

Enter the total number of therapy services involved for each procedure (e.g., 1, 1.5, 2).

Hearing Aid Providers:

For a hearing aid rental service, the total number of days the item was rented should be entered as the quantity. This must coincide with the service date range indicated. For hearing aid batteries, enter the number of batteries.

Element 24G - Type of Service (TOS)

Enter the appropriate type of service code. Refer to Attachment A-5 and A-5a of this bulletin for a list of allowable type of service codes for speech therapy.

ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

* *

Element 24H - Recipient Spenddown

Enter the spenddown amount, when applicable, on the last detail line of element 24H directly above element 29. Refer to MAPB-087-037-X dated September 1, 1987 for information on recipient spenddown.

ELEMENT 25 - PROVIDER SIGNATURE AND DATE

The provider or the authorized representative must sign in element 25. The month, day and year the form is signed must also be entered.

NOTE: This may be a computer printed name and date, or a signature stamp.

ELEMENT 26 -

(Not required, provider automatically accepts assignment through medical assistance certification.)

ELEMENT 27 - TOTAL CHARGE

Enter the total charges for this claim.

ELEMENT 28 - AMOUNT PAID

Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00.

ELEMENT 29 - BALANCE DUE

Enter the balance due as determined by subtracting the amount in element 24H and element 28 from the amount in element 27.

ELEMENT 30 - (not required)

ATTACHMENT A-2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR SPEECH THERAPY, AUDIOLOGY AND HEARING AID SERVICES

* *

ELEMENT 31 - PROVIDER NAME AND ID NUMBER

Enter the name, address, city, state and zip code of the billing provider. At the bottom of element 31 enter the billing provider's eight digit provider number. If the provider number indicated in element 31 is not the actual provider of service, the performing provider's number must be entered beneath the description of service in element 24C.

ELEMENT 32 - PATIENT ACCOUNT NUMBER

Optional - provider may enter the patient's internal office account number. This number will appear on the EDS Remittance and Status Report (maximum of twelve characters).

ELEMENT 33 - (not required)